

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15474

CERTIFICATE OF DEATH

15473

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>13.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethany Lane</u>		d. STREET ADDRESS <u>Bethany Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian V. Falter</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>Nov. 8 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/03</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Telephone Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dirsey</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-6178</u>	
17. INFORMANT <u>Mrs. Audrey Waters</u> <u>Bethany Lane-Ellicott City, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Chronic myocardial disease</u> DUE TO (c) <u>Arteriosclerotic Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 mos.</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-26, 1960</u> , to <u>11-8, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-7, 1967</u> , and that death occurred at <u>7:54 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas G. Herbert</u>		22b. DATE SIGNED <u>11-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas Herbert, M.D.</u>		22d. ADDRESS <u>44 Church Road, Ellicott City, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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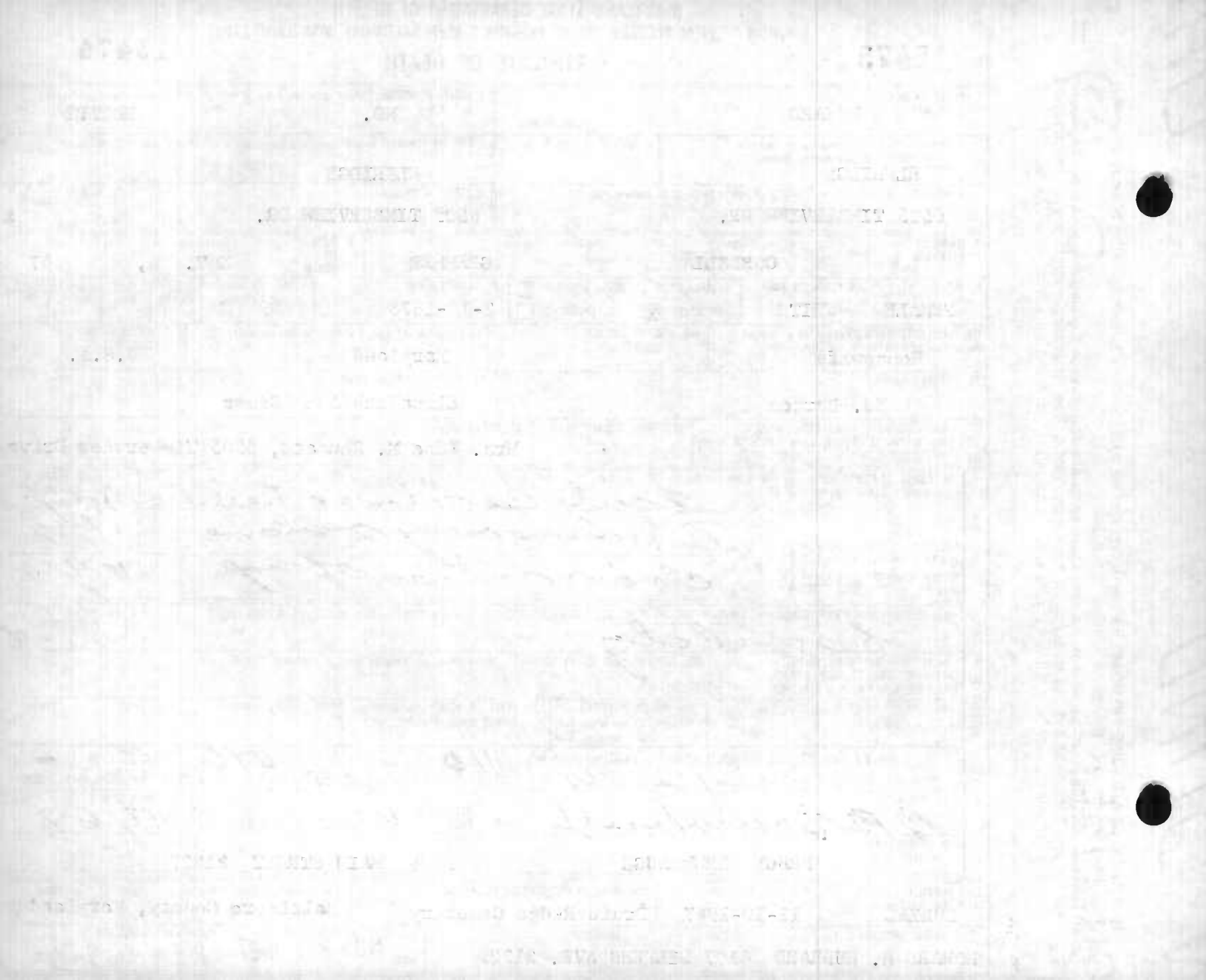
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE		c. LENGTH OF STAY IN 1b 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6505 TIMBERVIEW DR.		e. STREET ADDRESS 6505 TIMBERVIEW DR.	
3. NAME OF DECEASED (Type or print) First Middle Last CORDELIA GRAMMER		4. DATE OF DEATH Month Day Year NOV. 6, 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1878
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed. Burton		14. MOTHER'S MAIDEN NAME Elizabeth Ann Simms	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Edna M. Shumate, 6505 Timberview Drive		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO <u>pulmonary edema</u> (b) <u>conformities of age</u> DUE TO <u>conformities of age</u> (c) <u>conformities of age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>67</u> , to <u>4/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> , 19 <u>67</u> , and that death occurred at <u>1:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bruce Brumbaugh</u>		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) BRUCE BRUMBAUGH		22d. ADDRESS 5609 MAIN STREET 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR NOV 8 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



15475

CERTIFICATE OF DEATH

15475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tridelphia Rd		d. STREET ADDRESS Tridelphia Rd	
3. NAME OF DECEASED (Type or print) Dorothy Anderson Knight		4. DATE OF DEATH Month November Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1908
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Anderson		14. MOTHER'S MAIDEN NAME Jennie Stuart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Edwin Knight		Address Ellicott City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1750 IMMEDIATE CAUSE (a) Cachexia DUE TO Adenocarcinoma of left ovary with ab- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) dominal metastases and ascites (c)			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) did not attended the deceased from Feb. 10 , 1967, to Novem 28 , 1967, that (I) we saw the deceased alive on Nov. 27 1967, and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Nov. 29, 1967
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22d. ADDRESS Clarksville, Md. 21029	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-1-67	23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR DATE DEC 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1942

RECORDS OF DEATH

1942

RECORDS OF DEATH

RECORDS OF DEATH

RECORDS OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>Rt. 144</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 144</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>Alinda</u> Middle <u>Musgrove</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>13</u> Day <u>1967</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sameul Reed</u>		14. MOTHER'S MARDEN NAME <u>Matilda Liddard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Catherine Miles - Woodbine, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sealed Myocardial Infarct</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert Thomas</u> M.D.		22. DATE SIGNED <u>Nov. 13, 1967</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Likerville, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>NOV 16 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15477

15477

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 44 Old Annapolis Rd.		d. STREET ADDRESS 44 Old Annapolis Rd.	
3. NAME OF DECEASED (Type or print) First Eleanor Middle C Last Nelson		4. DATE OF DEATH Month November Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/88
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-retired		10b. KIND OF BUSINESS OR INDUSTRY Dept. Pub. Welfare	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Nelson		14. MOTHER'S MAIDEN NAME Eleanor Cuddy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-5634	
17. INFORMANT Miss Mary Belle Nelson		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cerebral artery disease. DUE TO (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) arteriosclerosis and pericarditis of undiagnosed 2 years DUE TO (c) fever.			INTERVAL BETWEEN ONSET AND DEATH 2 mon
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 Nov 2 , 1967, that (I) (we) last saw the deceased alive on 12:01 AM 1967, and that death occurred at Nov 2 M, from causes and on the date stated above.			
22a. SIGNATURE Robert B. Taylor		22b. DATE SIGNED Nov 3, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Robert Taylor		22d. ADDRESS 111 Colombia Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/4/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE NOV 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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100-37

STATEMENT OF

Witness

Name

Address

Occupation

Relationship to Subject

Place of Birth

Date of Birth

Marital Status

Education

Employment

Signature

Subscribed and sworn to before me this _____ day of _____, 19____.

Notary Public

My Commission Expires _____

Witnessed by _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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Items 18-21 Film 395		MARYLAND STATE DEPARTMENT OF HEALTH	
11-27-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
15479		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Item #15-Tel. Call M.E. Office comb		15478	
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Passing through d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Nat. Pike 1 1/2 miles W. of Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 205 Brightside Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM WATSON PAPE SR.		4. DATE OF DEATH Month November Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	11. BIRTHPLACE (State or foreign country) Pikesville, Md.
13. FATHER'S NAME Charles L. Pape		14. MOTHER'S MAIDEN NAME Mary West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-7550	17. INFORMANT Mrs. Grace W. Pape, 205 Brightside Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Hypertensive/ Cardiovascular Disease/ 891.5 DUE TO (b) Carbon monoxide poisoning DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While in car	
20c. TIME OF INJURY Month, Day, Year Hour am Nov 7 19 67 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) near West Friendship Howard Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) November 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or town) (County) (State) Woodlawn, Baltimore, Md.
24. FUNERAL DIRECTOR Frank A. Jewell		25a. RECEIVED BY REGISTRAR Nov 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECEIVED BY THE U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

NOV 12 1900

TO THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY

RE: [illegible]

Very truly yours,
[illegible signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VR A15ME
3500 4-64

MEMORANDUM FOR THE RECORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15481											
15480											
1. PLACE OF DEATH a. COUNTY HOWARD PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 1 Box 290 HARDING ROAD						2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) a. STATE MD b. COUNTY PR. GEO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL d. STREET ADDRESS Rt 1 HARDING ROAD Box 290 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JOHN Middle GRAFTON Last RHODES						4. DATE OF DEATH Month Nov. Day 17 Year 19 67					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/1910		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY GASK ELEC CO		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN C. RHODES						14. MOTHER'S MAIDEN NAME SUSAN WILEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address LAUREL MD GLORIA E. RHODES Rt 1 Box 290 HARDING Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO (b) Coronary Atherosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr 54 hr 109 hr											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 57 , to 11/17 , 19 67 , that (I) (we) last saw the deceased alive on 11/16 , 19 67 , and that death occurred at 3:27 PM , from the causes and on the date stated above.											
22a. SIGNATURE J M Warren						M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/17/67			
22c. PHYSICIAN'S NAME (Type) J M WARREN						22d. ADDRESS Laurel Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov 21, 1967		23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEM.		23d. LOCATION (City, town or county) (State) Williamsport Md.			
24. FUNERAL DIRECTOR Edmund Dalglish						ADDRESS LAUREL, MD		25a. REC'D BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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STATE DEPARTMENT
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Rural Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaffer's Convalescent Retreat, Inc		d. STREET ADDRESS 3507 Hillsmere Rd. 21207	
3. NAME OF DECEASED (Type or print) Clara Belle Rutter		4. DATE OF DEATH Month November Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1886
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. S. Kemp		14. MOTHER'S MAIDEN NAME Isabelle G. Muir	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Kemp Rutter		Address 3507 Hillsmere Rd. Balto Md 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (husband) attended the deceased from February , 19 66 , to November , 19 67 , that (I) (was) last saw the deceased alive on October 25 , 19 67 , and that death occurred at 10: P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Millard T. Traband, Jr.</i>		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. Millard T. Traband, Jr.		22d. ADDRESS 1811 N. Rolling Road Balto Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/11/67	
23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Foring Byers		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Board

Virginia

Richmond

Albany, N.Y.

Albany, N.Y.

Albany, N.Y. 12202

Albany, N.Y. 12202

Letter

Letter

Letter

November 8, 1950

Dec. 1, 1950

Dec. 1, 1950

Dec. 1, 1950

Dec. 1, 1950

Albany, N.Y.

Albany, N.Y.

Albany, N.Y.

Albany, N.Y.

Charles K. Smith, 3007 Hill
Albany, N.Y. 12202

Company of

Albany, N.Y. 12202

Albany, N.Y. 12202

Albany, N.Y. 12202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

15483		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		15482	
1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy 13.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 3				d. STREET ADDRESS R.F.D. # 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willard Middle Ray Last Smith				4. DATE OF DEATH Month November Day 29 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1893	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (County & State, or foreign country) Mt. Airy, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David W. Smith				14. MOTHER'S MAIDEN NAME Alice V. Day			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-9030		17. INFORMANT Mrs Alice M. Smith,		Address Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease DUE TO 5 years (c) Diabetes mellitus 3 years						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 5, 1967 to Nov. 29, 1967 that (I) (we) last saw the deceased alive on Nov. 29, 1967 , and that death occurred at 12:10 AM from causes and on the date stated above.							
22a. SIGNATURE James P. Kerr				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/30/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22d. ADDRESS Damascus, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DATE DEC 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15484

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17104

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD, b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jessup		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 86 A Carroll Heights Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Hebron Last Wood		4. DATE OF DEATH Month 11 Day 30 Year 67	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1876
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Isaac Atkins		14. MOTHER'S MAIDEN NAME Marsha Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Jessup Address Box 86 A Carroll Heights Ave		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage Arteriosclerotic Vascular Disease with Hypertension 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George E. Burgtorf M.D.		22. DATE SIGNED 11-30-67	
EXAMINER'S NAME (Type) GEORGE E. BURGTORF M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-3-67	23c. NAME OF CEMETERY OR CREMATORY CARVER	23d. LOCATION (City or Town) (County) (State) CASH BLVD LAUREL MD
24. FUNERAL DIRECTOR WILLIAM T. MOTEN		25. REC'D BY REGISTRAR DEC 8 1967	
25a. ME (5) 6M 1/67		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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